

SERFF Tracking Number:	WDMM-127176233	State:	Arkansas
Filing Company:	Woodmen of the World Life Insurance Society	State Tracking Number:	49432
Company Tracking Number:			
TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
Product Name:	Life App 5055 R-05/11 & Related Forms		
Project Name/Number:	/		

## Filing at a Glance

Company: Woodmen of the World Life Insurance Society

Product Name: Life App 5055 R-05/11 &  
Related Forms

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: WDMM-  
127176233

SERFF Status: Closed-Approved-  
Closed

Co Tr Num:

Author: Kathy Dollen

Date Submitted: 08/01/2011

State: Arkansas

State Tr Num: 49432

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 08/08/2011

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments: These forms were  
filed with the Interstate Insurance Product  
Regulation Commission for use in our domicile  
state of Nebraska.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 08/08/2011

State Status Changed: 08/08/2011

Deemer Date:

Submitted By: Kathy Dollen

Filing Description:

Re: Fraternal Form Filing - Individual Life

(see list of forms below)

Created By: Kathy Dollen

Corresponding Filing Tracking Number:

We are submitting the enclosed forms for filing and/or approval. These forms are new and will replace the forms shown below.

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Form Number - Form Description - Replaces Form(s) - Approved - SERFF Tracking #

Form 5055 R-05/11 - Application for Individual Life Insurance and Membership - Form 5055 R-3/10 - 6/25/2010 - WDMM-126692087

Form 601 R-05/11 - Medical Supplementary Statement - Form 601 R-3/10 - 6/25/2010 - WDMM-126692087

Form 943 R-05/11 - Administrative Supplementary Statement - Form 943 R-3/10 - 6/25/2010 - WDMM-126692087

Form 956 R-05/11 - Underwriting Supplementary Statement - Form 956 R-3/10 - 6/25/2010 - WDMM-126692087

Form 836 R-05/11 - Avocation Questionnaire - Form 836 R-3/10 - 5/10/2010 - WDMM-126590160

Form 8217 5-11 - Ratification Form - Form 8217 3-10 - 5/10/2010 - WDMM-126590160

These forms will be used with approved life certificates. These forms will be produced in both paper and electronic form. The electronic form may have an electronic signature. Individually licensed field representatives will solicit both the paper and electronic forms. The forms are not intended for Internet use.

Application for Individual Life Insurance and Membership Form 5055 R-05/11 is a fully underwritten application which will be used to apply for a new certificate, to reinstate a certificate, and to change an existing certificate. However, only one of these transactions can be done per application form.

Supplementary Statements, Form 601 R-05/11, Form 943 R-05/11 and Form 956 R-05/11 will be used with Application Form 5055 R-05/11. The completion of a supplementary statement is required when, during the underwriting process, it is learned that on the original application an answer to a question was omitted or a question was answered "yes" but details were not given. The proposed insured will be required to complete only the corresponding question(s) on the appropriate supplementary statement. We do not require the completion of the entire form.

Completion of questionnaire Form 836 R-05/11 is required when on the original application an answer to the avocation question is "yes" and further details need to be gathered to underwrite the application.

Ratification Form 8217 5-11 will be made a part of the application and of the certificate issued whenever a change in application and/or coverage is made as described in the Statement of Variability for Form 8217 5-11.

A readability certification has also been enclosed for your review.

The enclosed forms are submitted in final print and are subject to only minor modification in paper stock, ink, border, company logo, and adaptation to electronic media and computer printing.

We appreciate your time and consideration.

## Company and Contact

SERFF Tracking Number: WDM-127176233 State: Arkansas  
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 Project Name/Number: /

### Filing Contact Information

Kathryn Dollen, Senior Compliance Analyst kdollen@woodmen.org  
 1700 FARNAM STREET 402-271-7885 [Phone]  
 OMAHA, NE 68102 402-449-7732 [FAX]

### Filing Company Information

Woodmen of the World Life Insurance Society	CoCode: 57320	State of Domicile: Nebraska
1700 FARNAM STREET	Group Code:	Company Type:
OMAHA, NE 68102	Group Name:	State ID Number:
(402) 271-7279 ext. [Phone]	FEIN Number: 47-0339250	

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### Filing Fees

Fee Required?	Yes
Fee Amount:	\$300.00
Retaliatory?	No
Fee Explanation:	\$50.00 per form X 6 forms = \$300.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Woodmen of the World Life Insurance Society	\$300.00	08/01/2011	50224202

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/08/2011	08/08/2011

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<i>Project Name/Number:</i>	<i>/</i>		

## Disposition

Disposition Date: 08/08/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability for Form 8217 5-11		Yes
Form	Application for Individual Life Insurance and Membership		Yes
Form	Medical Supplementary Statement		Yes
Form	Administrative Supplementary Statement		Yes
Form	Underwriting Supplementary Statement		Yes
Form	Avocation Questionnaire		Yes
Form	Ratification Form		Yes

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 5055 R-05/11	Application/ Enrollment Form	Application for Individual Life Insurance and Membership	Initial		50.200	5055 - Life App.pdf
	Form 601 R-05/11	Other	Medical Supplementary Statement	Initial		51.300	601 - Medical Supp Stmt.pdf
	Form 943 R-05/11	Other	Administrative Supplementary Statement	Initial		54.500	943 - Administrative Supp Stmt.pdf
	Form 956 R-05/11	Other	Underwriting Supplementary Statement	Initial		55.600	956 - Underwriting Supp Stmt.pdf
	Form 836 R-05/11	Other	Avocation Questionnaire	Initial		62.500	836 - Avocation Questionnaire .pdf
	Form 8217 5-11	Other	Ratification Form	Initial		61.300	8217 5-11.pdf

**WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
1700 Farnam Street Omaha, Nebraska 68102

APPLICATION FOR INDIVIDUAL  
LIFE INSURANCE AND  
MEMBERSHIP

New Certificate Number:  This Change to Affect Certificate Number:

Field Representative Code: 123456 ☒ New Certificate ☐ Reinstatement ☐ Change Existing Certificate ☐ Term Conversion

**1 PROPOSED INSURED (The insured is the applicant owner unless otherwise designated in Section 3.)**

First	Middle Initial	Last	Suffix	Social Security Number
John	K	Woodmen		123-45-6789

Street Address (Residence of Proposed Insured)	Apt/Unit #
1234 Main Street	

City	State	Zip	Email Address
Omaha	NE	68102	JWoodmen@Woodmen.org

☒ Mailing Address is the same as above Street Address

Mailing Address if Different from Residence	City	State	Zip

Sex	Date of Birth (MM/DD/YYYY)	Age Now	Rating Age	Birth State/Country	Telephone Day (402) 321-1234
M	11/01/1974	36	36	NE	Eve (402) 123-4321

**2 PROPOSED ADULT APPLICANT (Complete only if proposed insured is age 0 - 15.)**

First	Middle Initial	Last	Suffix	Social Security Number

Street Address (Residence of Proposed Adult Applicant)	Apt/Unit #

City	State	Zip	Occupation and Duties

☐ Mailing Address is the same as above Street Address

Mailing Address if Different from Residence	City	State	Zip

Email Address	Relationship to Proposed Insured (If Legal Guardian, submit copy of Letters of Guardianship)

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day
		Eve

**OWNERSHIP TYPE If no ownership type is checked, the proposed adult applicant will be the controller of the certificate.**

☐ **PROPOSED ADULT APPLICANT IS CONTROLLER** - The youth insured will be the owner of the certificate. The adult applicant will retain control over the certificate until the youth insured reaches the age of majority. The applicant controller can exercise all rights in the certificate, except for the right of assignment, on behalf of the youth insured until the youth insured reaches the age of majority.

☐ **PROPOSED ADULT APPLICANT IS OWNER** - The adult applicant will be the owner of the certificate. The adult applicant will have the right to exercise all rights in the certificate.

**3 PROPOSED APPLICANT OWNER (Complete only if different than proposed insured. Not applicable if the proposed insured is age 0-15.)**

Owner is: ☐ Individual, different than proposed insured ☐ Partnership ☐ Corporation ☐ Trust ☐ Other

Name	Social Security No./Tax ID No.

Street Address (Residence if Individual)	Apt./Unit #	State & Date of Trust/Corporation/Partnership
		Mo. Day Year

City	State	Zip	Email Address

☐ Mailing Address is the same as above Street Address

Mailing Address if Different from Street Address	City	State	Zip

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day	Relationship to Proposed Insured
		Eve	



**4 PROPOSED JOINT APPLICANT OWNER** (Complete only if different than proposed insured. Not applicable if the proposed insured is age 0-15.)

Joint Owner is: ☐ Individual, different than proposed insured ☐ Partnership ☐ Corporation ☐ Trust ☐ Other

Name \_\_\_\_\_ Social Security No./Tax ID No. \_\_\_\_\_

Street Address (Residence if Individual) \_\_\_\_\_ Apt./Unit # \_\_\_\_\_ State & Date of Trust/Corporation/Partnership  
Mo. Day Year

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email Address \_\_\_\_\_

☐ Mailing Address is the same as above Street Address

Mailing Address if Different from Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day Eve	Relationship to Proposed Insured
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☐ Check here if more than two owners. Complete a Supplementary Statement for additional owners.

**5 LODGE MEMBERSHIP (Applies to proposed insured.)**

- A. ☒ New Member - Assign to "Active" Lodge Number \_\_\_\_\_ 1 \_\_\_\_\_ State \_\_\_\_\_ NE \_\_\_\_\_
- B. ☐ Current Member - No Lodge Change
- C. ☐ Current Member - New Lodge Number \_\_\_\_\_ State \_\_\_\_\_ (Do Not Transfer Existing Certificates)
- D. ☐ Current Member - New Lodge Number \_\_\_\_\_ State \_\_\_\_\_ (Transfer All Existing Certificates)

**6 TYPE OF CHANGE OR TERM CONVERSION**

Certificate Number(s) to change or convert: \_\_\_\_\_

**CONVERSION**

☐ Convert \$ \_\_\_\_\_ of certificate or rider ☐ Retain \$ \_\_\_\_\_ as term insurance

☐ Exercise Additional Insurance Option/Guaranteed Insurability Rider option

Note: Flexible Life increases **ONLY** available as a result of AIO Rider attached to Flexible Life.

☐ Convert to a new product

Note: Increases **ONLY** available for Adjustable Life and Accumulation Universal Life.

☐ Increase existing certificate number \_\_\_\_\_ **BY** \$ \_\_\_\_\_

☐ Increase existing certificate number \_\_\_\_\_ so that the **total face amount** will be \$ \_\_\_\_\_

**CHANGE**

☐ 90 day change

☐ Consider for possible rate reduction/removal

☐ Consider for non-tobacco classification

☐ Decrease **TO** \$ \_\_\_\_\_

☐ Purchase paid-up insurance with refunds on deposit

☐ Change from Exclude to Include (Not Available for No Lapse Guarantee Universal Life)

☐ Change from Include to Exclude (Not Available for No Lapse Guarantee Universal Life)

Note: Increases **ONLY** available for Adjustable Life and Accumulation Universal Life.

☐ Increase existing certificate number \_\_\_\_\_ **BY** \$ \_\_\_\_\_

☐ Increase existing certificate number \_\_\_\_\_ so that the **total face amount** will be \$ \_\_\_\_\_

**7 LIFE INSURANCE**Kind of Basic Certificate Applied For: No Lapse GUAR UL (NLGUL) Amount \$ 50,000**Universal Life Only (Not available for No Lapse Guarantee Universal Life)**(Choose One) ☐ Include Cash Value ☐ Exclude Cash Value**For No Lapse Guarantee Universal Life Only**Planned Premium payable to certificate anniversary following age: (Choose One) ☒ 80 ☐ 100 ☐ 120**BENEFITS & RIDERS**Additional Insurance Option/Guaranteed Insurability Rider . . . . . ☐ Add Amount \$ \_\_\_\_\_  
(Not available for No Lapse Guarantee Universal Life) ☐ Reduce **TO** Amount \$ \_\_\_\_\_☐ RemoveAccidental Death Benefit Rider . . . . . ☐ Add Amount \$ \_\_\_\_\_☐ Reduce **TO** Amount \$ \_\_\_\_\_☐ RemoveDisability Income Rider . . . . . ☐ Reduce **TO** Amount \$ \_\_\_\_\_☐ RemoveAccelerated Death Benefit Rider (included unless "No" checked here) . . . ☐ No ☐ Add ☐ RemoveApplicant Waiver Rider . . . . . ☐ Add ☐ Remove

(Available only if Proposed Insured is age 0-15 and the Adult Applicant is Controller.)

A. Applicant's Certificate Number \_\_\_\_\_ **Applicant must be a member of Woodmen and age 16-55.**B. Is the applicant currently working at least 30 hours per week and performing his/her regular duties of employment? ☐ Yes ☐ No  
If "No", give details. \_\_\_\_\_C. In the past 5 years has the applicant filed for disability benefits or been compensated for a disabling condition? . . . ☐ Yes ☐ No  
If "Yes", give details. \_\_\_\_\_D. Is the applicant currently taking any medications? . . . . . ☐ Yes ☐ No  
If "Yes", state name of drug and condition requiring it. \_\_\_\_\_**ADDITIONAL BENEFITS & RIDERS AVAILABLE FOR TRADITIONAL LIFE ONLY**Kind of Term Rider: \_\_\_\_\_ . . . . ☐ Add Amount \$ \_\_\_\_\_☐ Reduce **TO** Amount \$ \_\_\_\_\_☐ RemoveWaiver of Premium Rider . . . . . ☐ Add ☐ RemoveAutomatic Premium Loan Provision . . . . . ☐ Add ☐ Remove**ADDITIONAL BENEFITS & RIDERS AVAILABLE FOR UNIVERSAL LIFE ONLY**Waiver of Monthly Deduction Rider . . . . . ☐ Add ☐ Remove2X Waiver of Monthly Deduction Rider . . . . . ☐ RemoveCost of Living Adjustment Rider . . . . . ☐ Remove

Waiver of Premium Rider on Adjustable Life Increases only

(original certificate must be issued prior to 9/88) . . . . . ☐ Add ☐ Remove

**8 REFUND OPTION**

Unless specifically stated otherwise in your contract, if no option, more than one option, or an unavailable option is checked, refunds will be:

- left with Woodmen at interest on renewable Term, No Lapse Guarantee and Accumulation Universal Life
- used to buy paid-up additions on Whole Life and Youth Term, or
- used as additional premium on Adjustable Life and Flexible Life

Available for Traditional Life Only	Available for Adjustable Life & Flexible Life Only	Available for No Lapse Guarantee And Accumulation Universal Life Only
<input type="checkbox"/> Cash <input type="checkbox"/> Paid-up additions <input type="checkbox"/> Left with Woodmen at interest <input type="checkbox"/> Apply to reduce annual premium (Not available with Pre-Authorized Collection)	<input type="checkbox"/> Cash <input type="checkbox"/> Used as Additional Premium For Adjustable Life and Flexible Life, after maximum cash value (Choose One): <input type="checkbox"/> Paid in cash <input type="checkbox"/> Used to purchase additional insurance <input type="checkbox"/> Left with Woodmen at interest	<input type="checkbox"/> Cash <input checked="" type="checkbox"/> Left with Woodmen at interest

**9 BENEFICIARY**

- ◆ For **reinstatements, changes and increases in face amounts**: Completion of this section will revoke all previous beneficiary designations for this certificate.
- ◆ For **term conversions**: Completion of this section will apply only to the new certificate issued as a result of this application. Previous beneficiary designations for any existing certificate or any portion of existing certificate(s) not converted as a result of this application will remain in effect and will not be revoked. If the beneficiary is to be changed for any existing certificate(s), please submit Beneficiary Change Form 181.
- ◆ For **Additional Insurance Option/Guaranteed Insurability Rider** option exercised to increase the face amount: Completion of this section will revoke all previous beneficiary designations for this certificate.
- ◆ For **new certificate issued as a result of exercising Additional Insurance Option/Guaranteed Insurability Rider** option: Completion of this section will apply to the new certificate only. Previous beneficiary designations for any existing certificate(s) will remain in effect and will not be revoked. If the beneficiary is to be changed for any existing certificate(s), please submit Beneficiary Change Form 181.

**PRIMARY BENEFICIARY**

Name	City	State	Relationship	Age or Date of Birth	Social Security/Tax ID No. (Last 4 Digits Only)
Joseph Woodmen	Omaha	NE	Brother	45	6789

**ALTERNATE BENEFICIARY**

Name	City	State	Relationship	Age or Date of Birth	Social Security/Tax ID No. (Last 4 Digits Only)

**UNLESS OTHERWISE STATED IN WRITING, THE FOLLOWING CONDITIONS APPLY**

- The death benefit, when paid to all surviving primary beneficiaries, is paid equally in one sum.
- If there are no surviving primary beneficiaries, the death benefit is paid equally in one sum to all surviving alternate beneficiaries.
- The beneficiary will have the right to change the method by which the death benefit is paid after the death of the insured.

**10 TOBACCO USAGE (Applies to proposed insured age 18 and over.)**

In the past **12 months**, has the proposed insured used tobacco/nicotine in any form, such as cigarettes, pipes, cigars, snuff or chewing tobacco OR smoking cessation products such as nicotine patches or nicorette gum? . . . . . ☐ Yes ☒ No

A. If "Yes", indicate date last used: mo. \_\_\_\_\_ yr. \_\_\_\_\_ Indicate form(s) used: \_\_\_\_\_  
If cigarettes, how many packs per day? \_\_\_\_\_ If cigars, indicate quantity and frequency: \_\_\_\_\_

B. If "No", has the proposed insured used tobacco/nicotine in any form OR smoking cessation products in the last **36 months**? . . . . . ☐ Yes ☒ No

**11 OCCUPATION (Applies to proposed insured age 16 and over.)**

Occupation and Duties Teacher	Annual Income (Nearest \$10,000) 50000	How Long in Present Occupation? 10y
Name of Employer and Nature of Business Abc High School	Address of Business 123 Education St	Previous Occupation

**12 NONMEDICAL (Applies to proposed insured age 14 and over.)**

A. Is the proposed insured currently a United States citizen? If "No", provide permanent resident card number: ☒ Yes ☐ No

B. Does the proposed insured have a current driver's license/permit?

☐ No, explain why no license/permit: \_\_\_\_\_

☒ Yes, Driver's License/Permit Number: 234567 State: NE

C. Has the proposed insured ever had a license/permit suspended or revoked? . . . . . ☐ Yes ☒ No

D. Has the proposed insured had any moving traffic violations or traffic accidents within the past three years? . . ☐ Yes ☒ No

E. Has the proposed insured been convicted of or pled guilty or no contest to driving while intoxicated or under the influence of a narcotic drug? . . . . . ☐ Yes ☒ No

F. Has the proposed insured been convicted of or pled guilty or no contest to a crime within the past 10 years, or is the proposed insured currently awaiting trial for any crime? . . . . . ☐ Yes ☒ No

G. Is the proposed insured currently on probation or parole? . . . . . ☐ Yes ☒ No

H. Is the proposed insured a member of the U.S. Armed Services or active reserve? . . . . . ☐ Yes ☒ No

If "Yes", has the proposed insured been alerted of possible deployment? If "Yes", give details below. . . . ☐ Yes ☐ No

**If any question C-H has been answered "Yes", give dates and full details.**

I. Within the next 12 months, does the proposed insured intend to travel or reside outside of the U.S., Canada or any U.S. territories? If "Yes", submit details on Form 956. . . . . ☐ Yes ☒ No

J. In the past 3 years has the proposed insured participated in aviation as a pilot, crew member or student – to include sky diving, hang gliding, ballooning, ultralight, and other sky sports – or intends to within the next 2 years? If "Yes", submit an Aviation Questionnaire. . . . . ☐ Yes ☒ No

K. In the past 3 years has the proposed insured participated in racing of any type, skin or scuba diving, boxing, ultimate fighting or mountain climbing – or intends to within the next 2 years? If "Yes", submit an Avocation Questionnaire . . . . . ☐ Yes ☒ No

**13 YOUTH INFORMATION (Applies to proposed insured age 0-15.)**

A. Does the child live with the natural or adoptive parent(s)? If "No", explain why . . . . . ☐ Yes ☐ No

B. Does the child have brothers and/or sisters? ☐ Yes ☐ No (If "Yes", indicate amount of coverage carried on each child and their ages.)

C. Indicate amount of insurance carried by Father \$ \_\_\_\_\_  
Indicate amount of insurance carried by Mother \$ \_\_\_\_\_

**14 INSURANCE NOW IN FORCE OR APPLIED FOR (Applies to proposed insured.)**

List all policies currently in force or applied for on the **proposed insured**. **If none, check here.** ☒

Company Name	Policy Number	Kind	Life Insurance Amount	Accidental Death Amount	Year Issued

**15 MEDICAL** Applies to proposed insured. If proposed insured is age 0-15, questions 1 through 9 are to be answered by whoever has the best knowledge of the child's health history. (Usually the person with whom the child resides.)

**1. Physician or medical facility that has the proposed insured's most complete and current medical records:**

Dr. Thomas Shepard (402) 322-3214

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Physician/Facility Name	Phone Number
111 Medical St	68102
Address	City
	State
	Zip

Date Last Seen 10/15/2010 Reason For Visit Annual Check-up

**2. Has the proposed insured had or ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any disease or disorder of the:** YES NO

- A. Brain or Nervous System – such as epilepsy, paralysis or mental illness – to include treatment or counseling for depression or anxiety? . . . . . A. ☐ ☒
- B. Respiratory System – such as emphysema, bronchitis, chronic obstructive pulmonary disease, asthma or sleep apnea – to include disorders of the eyes, ears, nose or throat? . . . . . B. ☐ ☒
- C. Circulatory System – such as high blood pressure, chest pain, heart attack, heart surgery, heart murmur, heart arrhythmia, stroke, carotid artery disease, congestive heart failure, anemia or other blood disorders? . . . . . C. ☐ ☒
- D. Digestive or Urinary Tract Systems – such as ulcer, colitis, hepatitis, kidney infection, kidney stones, protein, blood or sugar in the urine – to include diabetes and thyroid disorders? . . . . . D. ☐ ☒
- E. Musculoskeletal System – such as arthritis, osteoporosis, gout or back disorders? . . . . . E. ☐ ☒
- F. Reproductive System – such as prostate, testes, breasts, ovaries or uterus disorders? . . . . . F. ☐ ☒
- G. Immune System – such as connective tissue disorders, lupus, multiple sclerosis or scleroderma except those related to the Human Immunodeficiency Virus? . . . . . G. ☐ ☒

**3. Has the proposed insured ever:**

- A. Been diagnosed or treated for cancer or tumor of any kind? . . . . . A. ☐ ☒
- B. Had or been advised to have any surgical operation? . . . . . B. ☐ ☒
- C. Been treated or received counseling for alcohol use, alcoholism or drug addiction? If "Yes", submit an Alcohol & Drug Questionnaire . . . . . C. ☐ ☒
- D. Used narcotics, barbiturates, excitant drugs, hallucinogens or tranquilizers without a prescription by a physician? If "Yes", submit an Alcohol & Drug Questionnaire . . . . . D. ☐ ☒

**4. Has the proposed insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS Virus) or Acquired Immune Deficiency Syndrome (AIDS)?** . . . . . 4. ☐ ☒

**5. At any time in the past five years, has the proposed insured been treated or diagnosed by a medical professional with any other illness or injury not mentioned above?** . . . . . 5. ☐ ☒

**6. During the past five years has the proposed insured:**

- A. Consulted, been examined by, treated by or received diagnostic tests (e.g., X-rays, ECG, or blood studies except those tests related to the Human Immunodeficiency Virus (AIDS Virus)) from a physician, hospital, clinic or similar institution? . . . . . A. ☐ ☒

**15 MEDICAL, Continued**

6. B. Received a pension, applied for or been compensated for disability? If "Yes", please explain . . . . . B. ☐ ☒
- C. Had an application for life, health, accident or disability insurance declined, postponed, rated up or modified?  
If "Yes", please explain what action was taken and why . . . . . C. ☐ ☒
7. **Does the proposed insured take medication, use medical assistive devices or equipment (e.g. CPAP, oxygen)?** If "Yes", state the name of the drug or describe the device and condition requiring it. . . . . 7. ☐ ☒
8. **Is the proposed insured now pregnant?** If "Yes", indicate due date and if any complications of this pregnancy have been diagnosed by a member of the medical profession. . . . . 8. ☐ ☐
9. A. **Proposed Insured's Height:** 6 ft. 0 in. **Weight:** 210 lbs.
- B. Has weight changed more than 15 pounds in the past year? If "Yes", indicate how much and by what means: B. ☐ ☒

**If any question 2-8 has been answered "Yes", give full details below:**

Question Number	Diagnosis	Treatment/ Medication	Dates From/To	Name, Address & Phone Number Of Health Care Professional/Facility

If more space is needed for Medical details, include an additional page, signed and dated.

**16 FAMILY HISTORY (Applies to proposed insured.)**

- A. Has a parent or sibling been diagnosed or treated by a member of the medical profession for cardiovascular disease or cancer prior to age 60? . . . . . ☐ Yes ☒ No  
If "Yes", give details \_\_\_\_\_
- B. Did death of a parent or sibling occur prior to age 60 due to cardiovascular disease or cancer? . . . . . ☐ Yes ☒ No

**17 REPLACEMENT (Applies to applicant owner.)** On a youth application this will apply to the insured, unless the adult applicant is owner.

- A. Does the proposed applicant have any existing life insurance or annuity contracts? . . . . . ☐ Yes ☒ No
- B. Has or will any life or annuity contracts be replaced if the proposed certificate is issued? . . . . . ☐ Yes ☒ No
- C. Will a 1035 exchange be involved? (If "Yes", submit Form 1035 for companies other than Woodmen.) . . . . ☐ Yes ☒ No
- If B or C is answered "Yes", provide policy number and company information below for the policy being replaced.

Policy Number	Company Name	Address	City	State	Zip

**18 PREMIUM DEPOSIT**

<input type="checkbox"/> 1. Cash/Cash Equivalent (Submit Cash Receipt)	\$ _____	<input checked="" type="checkbox"/> 4. Check	\$ 104.00
<input type="checkbox"/> 2. Refunds on Deposit	\$ _____	<input type="checkbox"/> 5. Express Check	\$ _____
<input type="checkbox"/> 3. Internal Exchange	\$ _____	<input type="checkbox"/> 6. External 1035 Exchange	\$ _____
		<input type="checkbox"/> 7. No Premium Deposit Has Been Made	

Amount to be applied as Premium Deposit \$ 100.00  
(Do Not Include Dues)

Amount to be applied as Fraternal Dues \$ 4.00  
for 4 Months.

Payor Name: \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

If 1-5 is selected on an application for a new certificate, give conditional receipt to applicant.

If 2, 3, 5, or 6 is selected, submit proper authorization.

P.A.C. authorizations, List Bill, and 1035 exchange requests to companies other than Woodmen are NOT premium deposits for RECEIPT AND CONDITIONAL INSURANCE AGREEMENT purposes.

**Advance Premiums:** \$ \_\_\_\_\_ No future payments until advance premium depleted.

**For Conversions Only** – Any credits should be applied as follows:

☐ Additional Premium for Traditional Life    ☐ Premium for Universal Life    ☐ Refund any credits

**19 FOR UNIVERSAL LIFE ONLY (Not available for No Lapse Guarantee Universal Life)**

If the premium paid at issue or at any time thereafter would cause the certificate to be classified as a modified endowment contract (MEC) because the premium exceeds the amount allowed by the Internal Revenue Code (IRC), I choose one of the following:

- ☐ Allow the certificate to become a MEC (excess premium is added to the certificate's cash value).
- ☐ Not allow the certificate to become a MEC by placing the excess premium paid at issue or at any time thereafter into an advance premium/premium deposit fund that earns interest. Interest earned will be reported annually to the IRS. Woodmen is authorized to automatically transfer money from the advance premium/premium deposit fund to the certificate's cash value once a year. The amount transferred each year will not exceed the amount allowed by the IRC based on Woodmen's understanding of the requirements of the IRC.

**20 FUTURE BILLING**

<b>Billing Method</b>		<b>Frequency</b>
<input checked="" type="checkbox"/> New P.A.C. plan *	<input type="checkbox"/> Do Not Send Future Billing	<input type="checkbox"/> Annually
<input type="checkbox"/> Add to present P.A.C. plan (list one certificate number currently being paid on plan)	<input type="checkbox"/> Direct Bill	<input checked="" type="checkbox"/> Semiannually
<b>P.A.C. billing not available with refund option</b>	<input type="checkbox"/> Government Allotment (Military)	<input type="checkbox"/> Quarterly
<b>Apply To Reduce Annual Premium</b>	<input type="checkbox"/> List Bill *	<input type="checkbox"/> Monthly
CERTIFICATE NO. _____	Group Number: _____	
Payor's Name: _____	* Submit proper authorizations	
Bank Acct. No.: _____		

**For All Universal Life**  
Planned Premium, excluding fraternal dues, for selected frequency: \$ 100.00

**21 PAYOR INFORMATION**

☒ Proposed Insured    ☐ Adult Applicant    ☐ Applicant Owner    ☐ Joint Applicant Owner    ☐ Other (Complete below)

First                                      Middle Initial                      Last                                      Suffix

Address \_\_\_\_\_ Apt/Unit # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Relationship to Proposed Insured \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Social Security Number \_\_\_\_\_

**22 PARENT OR LEGAL GUARDIAN'S CONSENT****(To be completed ONLY when the proposed adult applicant is not a parent or legal guardian.)**

I, the parent or legal guardian, give my consent to this application on the child's life and the beneficiaries as designated.

I have received a copy of the "Notice Relating to the MIB (Medical Information Bureau)", "Notice Required Under the Fair Credit Reporting Act" and if applicable the "Notice of Information Practices".

**Certification Instructions** – You must cross out the language in item (2) within this box if the child has been notified by the IRS that the child is currently subject to backup withholding because of underreporting interest or dividends on a tax return.

Under penalties of perjury, I, the undersigned parent or legal guardian, certify:

- (1) the number shown on this application represents the correct Taxpayer Identification Number (TIN) of the proposed insured child AND
- (2) the same is not subject to backup withholding because: (a) the child is exempt from backup withholding, or (b) the child has not been notified by the IRS that he/she is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified the child that he/she is no longer subject to backup withholding, AND
- (3) the child is a United States person (including a United States resident alien).

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to the Proposed Insured  
(If Legal Guardian, submit copy of  
Letters of Guardianship)

**23 ACKNOWLEDGEMENT AND AGREEMENT**

The following statements must be read by or to the proposed insured and any proposed applicant owner or the proposed adult applicant:

I have received a copy of the "Notice Relating to the MIB (Medical Information Bureau)", "Notice Required Under the Fair Credit Reporting Act" and if applicable the "Notice of Information Practices".

The Accelerated Death Benefit Disclosure Statement has been given to me, the applicant owner, if applicable.

I have read this application. I represent that each of the answers and the information given therein is full, complete and true, to the best of my knowledge and belief, with the understanding that they shall be considered as representations and not warranties. I agree as follows:

1. Notice to or knowledge of any Field Representative or medical examiner as to information which relates to the proposed insured will not be notice to Woodmen unless it is in writing in this application.
2. Field Representatives do not have authority to (a) determine insurability; (b) change any terms of this application; (c) make or change a contract for Woodmen; (d) waive any rights or requirements of Woodmen. I understand that oral statements between the Field Representative and myself regarding such matters of limited authority are not binding on Woodmen unless accepted by Woodmen in writing.

I agree to be bound by the terms of this application and the life insurance certificate for which I am applying. I also agree to be bound by all obligations set forth in Woodmen's Articles of Incorporation and its Constitution and Laws and I acknowledge Woodmen's common bond and purpose.

**Applications for New Certificate:**

Except for coverage which may be provided in the RECEIPT AND CONDITIONAL INSURANCE AGREEMENT, no insurance will be in force because of this application until it has been approved and at least one monthly premium has been paid to Woodmen.

**Applications for Reinstatement, Change to Existing Certificate, or Term Conversion:**

I agree this application shall not be construed as extending temporary insurance coverage on the life of the proposed insured. Reinstatement of or change to existing insurance will be effective and coverage will commence on the date this application is approved in the Home Office of Woodmen.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.



**23 ACKNOWLEDGEMENT AND AGREEMENT (Continued)**

**Certification Instructions**-You must cross out the language in item (2) within this box if you (and/or the child) have been notified by the IRS that you (and/or the child) are currently subject to backup withholding because of underreporting interest or dividends on a tax return.

Under penalties of perjury, I, the undersigned applicant, certify:

- (1) the number(s) shown on this application represents my (and/or the child's) correct Taxpayer Identification Number (TIN) AND  
 (2) I (and/or the child) am not subject to backup withholding because: (a) I (and/or the child) am exempt from backup withholding, or  
 (b) I (and/or the child) have not been notified by the IRS that I (and/or the child) am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me (and/or the child) that I (and/or the child) am no longer subject to backup withholding, AND  
 (3) I (and/or the child) am a United States person (including a United States resident alien).

**The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Signed at Omaha NE  
 City State

☐ **By checking this box, I, the proposed applicant, acknowledge this application was signed in a different state than the state in which I reside.**

John K Woodmen 04/01/2011  
 Signature of Proposed Insured, Date  
 if age 16 or older OR  
 Signature of Proposed Adult Applicant

\_\_\_\_\_  
 Signature of Proposed Applicant Owner Date  
 if not Proposed Insured &  
 Title if Trust/Corporation/Partnership

\_\_\_\_\_  
 Signature of Proposed Joint Applicant Owner Date  
 & Title if Trust/Corporation/Partnership

\_\_\_\_\_  
 Signature of Proposed Joint Applicant Owner Date  
 & Title if Trust/Corporation/Partnership

\_\_\_\_\_  
 Signature of Proposed Joint Applicant Owner Date  
 & Title if Trust/Corporation/Partnership

**24 FIELD REPRESENTATIVE'S CERTIFICATION** Questions 2 and 3 apply to applicant owner. On a youth application, questions will apply to the insured, unless the adult applicant is owner. Submit replacement forms, if required.

1. Were you present when this application was signed? (If "No", submit a full explanation with the application) . . . ☒ Yes ☐ No  
 2. Does the proposed applicant have any existing life insurance or annuity contracts? . . . . . ☐ Yes ☒ No  
 3. Do you have knowledge or reason to believe that replacement of any insurance or annuities was or may be involved? . . . . . ☐ Yes ☒ No  
 4. I asked each question exactly as written and accurately recorded the information supplied in this application.

Primary FR Code \_\_\_\_\_ %  
 Secondary FR Code \_\_\_\_\_ %  
 Third FR Code \_\_\_\_\_ %

Thomas K Smith 04/01/2011  
 Field Representative's Signature Date

Thomas K Smith  
 Field Representative's Name Printed

☒ **WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
☐ **OMAHA WOODMEN LIFE INSURANCE SOCIETY**  
**1700 Farnam Street Omaha, Nebraska 68102**

CERTIFICATE NUMBER

MEDICAL  
SUPPLEMENTARY  
STATEMENT

☒ New Certificate ☐ Change Existing Certificate

☐ Reinstatement ☐ Term Conversion

Field Representative Code: 123456

**PROPOSED INSURED (The insured is the applicant owner unless otherwise designated.)**

First	Middle Initial	Last	Suffix
John	K	Woodmen	

Date of Birth (MM/DD/YYYY)

11/01/1974

Social Security Number

123-45-6789

**MEDICAL** Applies to proposed insured. If proposed insured is age 0-15, questions 1 through 9 are to be answered by whoever has the best knowledge of the child's health history. (Usually the person with whom the child resides.)

1. **Physician or medical facility that has the proposed insured's most complete and current medical records:**

Physician/Facility Name		Phone Number	
Address	City	State	Zip
Date Last Seen		Reason For Visit	

2. **Has the proposed insured had or ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for any disease or disorder of the:**

YES NO

- A. Brain or Nervous System – such as epilepsy, paralysis or mental illness – to include treatment or counseling for depression or anxiety? . . . . . A. ☐ ☐
- B. Respiratory System – such as emphysema, bronchitis, chronic obstructive pulmonary disease, asthma or sleep apnea – to include disorders of the eyes, ears, nose or throat? . . . . . B. ☐ ☐
- C. Circulatory System – such as high blood pressure, chest pain, heart attack, heart surgery, heart murmur, heart arrhythmia, stroke, carotid artery disease, congestive heart failure, anemia or other blood disorders? . . . . . C. ☐ ☐
- D. Digestive or Urinary Tract Systems – such as ulcer, colitis, hepatitis, kidney infection, kidney stones, protein, blood or sugar in the urine – to include diabetes and thyroid disorders? . . . . . D. ☐ ☐
- E. Musculoskeletal System – such as arthritis, osteoporosis, gout or back disorders? . . . . . E. ☐ ☐
- F. Reproductive System – such as prostate, testes, breasts, ovaries or uterus disorders? . . . . . F. ☐ ☐
- G. Immune System – such as connective tissue disorders, lupus, multiple sclerosis or scleroderma except those related to the Human Immunodeficiency Virus? . . . . . G. ☐ ☐

3. **Has the proposed insured ever:**

- A. Been diagnosed or treated for cancer or tumor of any kind? . . . . . A. ☐ ☒
- B. Had or been advised to have any surgical operation? . . . . . B. ☐ ☐
- C. Been treated or received counseling for alcohol use, alcoholism or drug addiction? If "Yes", submit an Alcohol & Drug Questionnaire . . . . . C. ☐ ☐
- D. Used narcotics, barbiturates, excitant drugs, hallucinogens or tranquilizers without a prescription by a physician? If "Yes", submit an Alcohol & Drug Questionnaire . . . . . D. ☐ ☐

4. **Has the proposed insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?** . . . . . 4. ☐ ☐

5. **At any time in the past five years, has the proposed insured been treated or diagnosed by a medical professional with any other illness or injury not mentioned above?** . . . . . 5. ☐ ☐

6. **During the past five years has the proposed insured:**

- A. Consulted, been examined by, treated by or received diagnostic tests (e.g., X-rays, ECG, or blood studies except those tests related to the Human Immunodeficiency Virus (AIDS Virus)) from a physician, hospital, clinic or similar institution? . . . . . A. ☐ ☐
- B. Received a pension, applied for or been compensated for disability? If "Yes", please explain. . . . . B. ☐ ☐
- C. Had an application for life, health, accident or disability insurance declined, postponed, rated up or modified? If "Yes", please explain what action was taken and why . . . . . C. ☐ ☐

YES NO

7. **Does the proposed insured take medication, use medical assistive devices or equipment (e.g. CPAP, oxygen)?** If "Yes", state the name of the drug or describe the device and condition requiring it. . . . . 7. ☐ ☐
8. **Is the proposed insured now pregnant?** If "Yes", indicate due date and if any complications of this pregnancy have been diagnosed by a member of the medical profession. . . . . 8. ☐ ☐
9. A. **Proposed Insured's Height:** \_\_\_\_\_ ft. \_\_\_\_\_ in. **Weight:** \_\_\_\_\_ lbs.  
 B. Has weight changed more than 15 pounds in the past year? If "Yes", indicate how much and by what means: B. ☐ ☐

**If any question 2-8 has been answered "Yes", give full details below:**

Question Number	Diagnosis	Treatment/ Medication	Dates From/To	Name, Address & Phone Number Of Health Care Professional/Facility

If more space is needed for Medical details, include an additional page, signed and dated.

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

*John K Woodmen*

Signature of Proposed Insured,  
 if age 16 or older OR  
 Signature of Proposed Adult Applicant

04/01/2011  
 Date

☒ **WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**

☐ **OMAHA WOODMEN LIFE INSURANCE SOCIETY**

**1700 Farnam Street Omaha, Nebraska 68102**

Field Representative Code: 123456

CERTIFICATE NUMBER

ADMINISTRATIVE  
SUPPLEMENTARY  
STATEMENT

☒ New Certificate ☐ Change Existing Certificate

☐ Reinstatement ☐ Term Conversion

**PROPOSED INSURED (The insured is the applicant owner unless otherwise designated.)**

First	Middle Initial	Last	Suffix
John	K	Woodmen	

Date of Birth (MM/DD/YYYY)	Social Security Number
11/01/1974	123-45-6789

**1 CLARIFICATION OF PROPOSED INSURED'S NAME**

Please provide the correct full name.

First	Middle Initial	Last	Suffix
John	K	Woodmen	

**2 CLARIFICATION OF PROPOSED APPLICANT'S NAME**

The proposed applicant's name on the application and the signature differ. Please print your correct name.

First	Middle Initial	Last	Suffix

**3 PROPOSED ADULT APPLICANT (Complete only if proposed insured is age 0 - 15.)**

First	Middle Initial	Last	Suffix	Social Security Number

Street Address (Residence of Proposed Adult Applicant)	Apt./Unit #

City	State	Zip	Occupation and Duties

☐ Mailing Address is the same as above Street Address

Mailing Address if Different from Residence	City	State	Zip

Email Address

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day	Eve

Relationship to Proposed Insured  
(If Legal Guardian, submit copy of  
Letters of Guardianship)

**OWNERSHIP TYPE If no ownership type is checked, the proposed adult applicant will be the controller of the certificate.**

☐ **PROPOSED ADULT APPLICANT IS CONTROLLER** - The youth insured will be the owner of the certificate. The adult applicant will retain control over the certificate until the youth insured reaches the age of majority. The applicant controller can exercise all rights in the certificate, except for the right of assignment, on behalf of the youth insured until the youth insured reaches the age of majority.

☐ **PROPOSED ADULT APPLICANT IS OWNER** - The adult applicant will be the owner of the certificate. The adult applicant will have the right to exercise all rights in the certificate.

**4 PROPOSED JOINT APPLICANT OWNER (Complete only if different than proposed insured. Not applicable if the proposed insured is age 0-15.)**

Joint Owner is: ☐ Individual, different than proposed insured ☐ Partnership ☐ Corporation ☐ Trust ☐ Other

Name	Social Security No./Tax ID No.

Street Address (Residence if Individual)	Apt./Unit #	State & Date of Trust/Corporation/Partnership
		Mo. Day Year

City	State	Zip	Email Address

☐ Mailing Address is the same as above Street Address

Mailing Address if Different from Street Address	City	State	Zip

Sex	Date of Birth (MM/DD/YYYY)	Telephone Day	Eve	Relationship to Proposed Insured

**4 PROPOSED JOINT APPLICANT OWNER, (Continued)**

Joint Owner is: ☐ Individual, different than proposed insured ☐ Partnership ☐ Corporation ☐ Trust ☐ Other

Name \_\_\_\_\_ Social Security No./Tax ID No. \_\_\_\_\_

Street Address (Residence if Individual) \_\_\_\_\_ Apt./Unit # \_\_\_\_\_ State & Date of Trust/Corporation/Partnership \_\_\_\_\_  
Mo. Day Year

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email Address \_\_\_\_\_

☐ Mailing Address is the same as above Street Address

Mailing Address if Different from Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Telephone Day \_\_\_\_\_ Eve \_\_\_\_\_ Relationship to Proposed Insured \_\_\_\_\_

**5 APPLICANT WAIVER RIDER (Youth Applications Only - Proposed Insured Age 0-15 and the Adult Applicant is Controller.)**

- Applicant Waiver Rider . . . . . ☐ Add ☐ Remove
- A. Applicant's Certificate Number: \_\_\_\_\_ **Applicant must be a member of Woodmen and age 16-55.**
- B. Is the applicant currently working at least 30 hours per week and performing his/her regular duties of employment? ☐ Yes ☐ No  
If "No", give details. \_\_\_\_\_
- C. In the past 5 years has the applicant filed for disability benefits or been compensated for a disabling condition? . . . ☐ Yes ☐ No  
If "Yes", give details. \_\_\_\_\_
- D. Is the applicant currently taking any medications? . . . . . ☐ Yes ☐ No  
If "Yes", state name of drug and condition requiring it. \_\_\_\_\_

**6 INSURANCE NOW IN FORCE OR APPLIED FOR (Applies to proposed insured.)**

List all policies currently in force or applied for on the **proposed insured**. **If none, check here.** ☐

Company Name	Policy Number	Kind	Life Insurance Amount	Accidental Death Amount	Year Issued

**7 REPLACEMENT (Applies to applicant owner.)** On a youth application this will apply to the insured, unless the adult applicant is owner.

- A. Does the proposed applicant have any existing life insurance or annuity contracts? . . . . . ☐ Yes ☐ No
- B. Has or will any life or annuity contracts be replaced if the proposed certificate is issued? . . . . . ☐ Yes ☐ No
- C. Will a 1035 exchange be involved? (If "Yes", submit Form 1035 for companies other than Woodmen.) . . . . . ☐ Yes ☐ No
- If B or C is answered "Yes", provide policy number and company information below for the policy being replaced.

Policy Number	Company Name	Address	City	State	Zip

**8 VERIFICATION OF STATE SIGNED**

The state in which I signed the application was: \_\_\_\_\_

**9 VERIFICATION OF THE DATE OF APPLICATION**

The date I signed the application was: \_\_\_\_\_

**10 FIELD REPRESENTATIVE'S CERTIFICATION**

Questions 2 and 3 apply to applicant owner. On a youth application, questions will apply to the insured, unless the adult applicant is owner. Submit replacement forms, if required.

1. Were you present when this application was signed? (If "No", submit a full explanation). . . . . ☐ Yes ☐ No
2. Does the proposed applicant have any existing life insurance or annuity contracts? . . . . . ☐ Yes ☐ No
3. Do you have knowledge or reason to believe that replacement of any insurance or annuities was or may be involved? ☐ Yes ☐ No
4. I asked each question exactly as written and accurately recorded the information supplied in this application.

\_\_\_\_\_  
Field Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Field Representative's Name Printed

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

John K Woodmen

Signature of Proposed Insured,  
if age 16 or older OR  
Signature of Proposed Adult Applicant

2011/04/01

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Applicant Owner  
if not Proposed Insured &  
Title if Trust/Corporation/Partnership

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Joint Applicant Owner  
& Title if Trust/Corporation/Partnership

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Joint Applicant Owner  
& Title if Trust/Corporation/Partnership

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Joint Applicant Owner  
& Title if Trust/Corporation/Partnership

\_\_\_\_\_  
Date

☒ **WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
☐ **OMAHA WOODMEN LIFE INSURANCE SOCIETY**  
1700 Farnam Street Omaha, Nebraska 68102

CERTIFICATE NUMBER

UNDERWRITING  
SUPPLEMENTARY  
STATEMENT

Field Representative Code: 123456

☒ New Certificate ☐ Change Existing Certificate  
☐ Reinstatement ☐ Term Conversion

**PROPOSED INSURED (The insured is the applicant owner unless otherwise designated.)**

First John	Middle Initial K	Last Woodmen	Suffix
---------------	---------------------	-----------------	--------

Date of Birth (MM/DD/YYYY) 11/01/1974	Social Security Number 123-45-6789
--	---------------------------------------

**1 TOBACCO USAGE (Applies to proposed insured age 18 and over.)**

In the past **12 months**, has the proposed insured used tobacco/nicotine in any form, such as cigarettes, pipes, cigars, snuff or chewing tobacco OR smoking cessation products such as nicotine patches or nicorette gum? . . . . . ☐ Yes ☒ No

A. If "Yes", indicate date last used: mo. \_\_\_\_\_ yr. \_\_\_\_\_ Indicate form(s) used: \_\_\_\_\_

If cigarettes, how many packs per day? \_\_\_\_\_ If cigars, indicate quantity and frequency: \_\_\_\_\_

B. If "No", has the proposed insured used tobacco/nicotine in any form OR smoking cessation products in the last **36 months**? . . . . . ☐ Yes ☒ No

**2 OCCUPATION (Applies to proposed insured age 16 and over.)**

Occupation and Duties	Annual Income (Nearest \$10,000)	How Long in Present Occupation?
-----------------------	-------------------------------------	------------------------------------

Name of Employer and Nature of Business	Address of Business	Previous Occupation
---	---------------------	---------------------

**3 NONMEDICAL (Applies to proposed insured age 14 and over.)**

A. Is the proposed insured currently a United States citizen? If "No", provide permanent resident card number: ☐ Yes ☐ No

B. Does the proposed insured have a current driver's license/permit?

☐ No, explain why no license/permit: \_\_\_\_\_

☐ Yes, Driver's License/Permit Number: \_\_\_\_\_ State: \_\_\_\_\_

C. Has the proposed insured ever had a license/permit suspended or revoked? . . . . . ☐ Yes ☐ No

D. Has the proposed insured had any moving traffic violations or traffic accidents within the past three years? . . . . . ☐ Yes ☐ No

E. Has the proposed insured been convicted of or pled guilty or no contest to driving while intoxicated or under the influence of a narcotic drug? . . . . . ☐ Yes ☐ No

F. Has the proposed insured been convicted of or pled guilty or no contest to a crime within the past 10 years, or is the proposed insured currently awaiting trial for any crime? . . . . . ☐ Yes ☐ No

G. Is the proposed insured currently on probation or parole? . . . . . ☐ Yes ☐ No

H. Is the proposed insured a member of the U.S. Armed Services or active reserve? . . . . . ☐ Yes ☐ No

If "Yes", has the proposed insured been alerted of possible deployment? If "Yes", give details below. . . . . ☐ Yes ☐ No

**If any question C-H has been answered "Yes", give dates and full details:**

I. Within the next 12 months, does the proposed insured intend to travel or reside outside of the U.S., Canada or any U.S. territories? If "Yes", complete Section 6 on this form . . . . . ☐ Yes ☐ No

J. In the past 3 years has the proposed insured participated in aviation as a pilot, crew member or student – to include sky diving, hang gliding, ballooning, ultralight, and other sky sports – or intends to within the next 2 years? If "Yes", submit an Aviation Questionnaire . . . . . ☐ Yes ☐ No

K. In the past 3 years has the proposed insured participated in racing of any type, skin or scuba diving, boxing, ultimate fighting or mountain climbing – or intends to within the next 2 years? If "Yes", submit an Avocation Questionnaire . . . . . ☐ Yes ☐ No

**4 YOUTH INFORMATION (Applies to proposed insured age 0-15.)**

- A. Does the child live with the natural or adoptive parent(s)? . . . . . ☐ Yes ☐ No  
If "No", explain why \_\_\_\_\_
- B. Does the child have brothers and/or sisters? ☐ Yes ☐ No (If "Yes", indicate amount of coverage carried on each child and their ages.)  
\_\_\_\_\_
- C. Indicate amount of insurance carried by Father \$ \_\_\_\_\_  
Indicate amount of insurance carried by Mother \$ \_\_\_\_\_

**5 FAMILY HISTORY (Applies to proposed insured.)**

- A. Has a parent or sibling been diagnosed or treated by a member of the medical profession for cardiovascular disease or cancer prior to age 60? . . . . . ☐ Yes ☐ No  
If "Yes", give details \_\_\_\_\_
- B. Did death of a parent or sibling occur prior to age 60 due to cardiovascular disease or cancer? . . . . . ☐ Yes ☐ No

**6 TRAVEL (Applies to proposed insured.)**

Please provide the following details for any travel plans you have to locations other than the United States (and its territories or Canada):

1. What country, or countries, do you plan on traveling to? \_\_\_\_\_
2. What city or cities do you plan to visit? \_\_\_\_\_
3. When do you plan on going? \_\_\_\_\_
4. How long do you plan on being there? \_\_\_\_\_
5. What is the purpose of the trip? \_\_\_\_\_
6. Will medical and sanitation facilities be accessible? \_\_\_\_\_

**Provide any additional information relating to the above questions that would be helpful in consideration of the application.**

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

<u><i>John K Woodmen</i></u> Signature of Proposed Insured, if age 16 or older OR Signature of Proposed Adult Applicant	<u>04/01/2011</u> Date
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☒ **WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
☐ **OMAHA WOODMEN LIFE INSURANCE SOCIETY**  
**1700 Farnam Street Omaha, Nebraska 68102**

Field Representative Code: 123456

CERTIFICATE NUMBER

AVOCATION  
QUESTIONNAIRE

☒ New Certificate ☐ Change Existing Certificate  
☐ Reinstatement ☐ Term Conversion

**PROPOSED INSURED (The insured is the applicant owner unless otherwise designated.)**

First John Middle Initial K Last Woodmen Suffix \_\_\_\_\_  
Date of Birth (MM/DD/YYYY) 05/05/1980 Social Security Number 123-45-5689

**1 RACING SPORTS**

TYPE: ☐ Drag ☐ Indy Car ☐ Kart ☐ Midget ☐ Formula ☐ GT ☐ Rally ☐ Production ☐ Sprint ☐ Stock ☐ Open Wheel ☐ Motorcycle ☐ Boat ☐ Other \_\_\_\_\_ Vehicle Category \_\_\_\_\_  
Racing Division: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ Horsepower: \_\_\_\_\_  
Type of Fuel: \_\_\_\_\_ Highest attained speed during race \_\_\_\_\_ mph. Elapsed Time: \_\_\_\_\_  
Through what organization is vehicle sanctioned? \_\_\_\_\_ In what class do you race? \_\_\_\_\_  
Track: ☐ Oval Track ☐ Closed Circuit ☐ Drag Strip ☐ Hill Climb ☐ Other: \_\_\_\_\_ Track Length \_\_\_\_\_  
Track Surface \_\_\_\_\_ Number of races last 12 mos. \_\_\_\_\_ Avg. length of race \_\_\_\_\_ Number of races next 12 mos. \_\_\_\_\_

**2 SCUBA DIVING**

TYPE: ☒ Open Water ☐ Photography ☐ Spear Fishing ☐ Cave ☐ Salvage/Treasure ☐ Wreck diving with penetration  

Maximum Depth →	To 75 Ft.	76-100 Ft.	101-130 Ft.	OVER 130 Ft.	Avg. time under water per dive
No. of dives next 12 months	7				
No. of dives past 12 months	6				
No. of dives in previous 13-24 months	7				

Have you received one of the following National Certifications? ☐ PADI ☐ NAUI ☐ NASDS ☐ YMCA  
Have you received one of the following diving certifications: ☐ Diving with an instructor ☐ Basic Cert. ☐ Open Water Cert.  
☐ Adv. Open Water Cert. ☐ Specialty Course Cave ☐ Specialty Course Wreck ☐ Specialty Course Other \_\_\_\_\_  
☐ Dive Master Cert. ☐ Ass't. Instructor or Instructor ☐ Master Instructor ☐ Master Scuba Diver  
If diving over 75 ft., please describe location, type of dive and if it was supervised: \_\_\_\_\_  
Do you use the buddy system? ☐ Yes ☒ No Location of dives: ☐ Oceans ☐ Pools ☒ Lakes/Rivers ☐ Bays/Inlets

**3 BOXING, ULTIMATE FIGHTING**

1. Please identify which of the activities you participate in: ☐ Ultimate Fighting ☐ Boxing  
Boxing Type: ☐ Golden Glove ☐ Olympic ☐ Championship ☐ Other (Explain in No. 3 below)  
2. Number of fights: Last 12 mos. \_\_\_\_\_ Past 13-36 mos. \_\_\_\_\_ Est. next 12 mos. \_\_\_\_\_  
3. Details:

**4 MOUNTAIN CLIMBING**

How many years of experience climbing do you have? \_\_\_\_\_ How many times per year do you climb? \_\_\_\_\_  
Usual duration of climb? Hours: \_\_\_\_\_ Days: \_\_\_\_\_ Average Height? \_\_\_\_\_ Trail: ☐ Yes ☐ No Rock: ☐ Yes ☐ No  
Have you had any climbing accidents? ☐ Yes ☐ No Do you plan on climbing outside the U.S.? . . . . . ☐ Yes ☐ No  
Do you climb alone? ☐ Yes ☐ No Is the insurance coverage being used to cover any type of climbing event? ☐ Yes ☐ No  
For any "Yes" answers in Section 4, please explain (regarding nature, location, frequency and degree of participation).

**I have read the answers written above. I ratify and agree to be bound by such answers and agree that they are true and complete to the best of my knowledge and belief. I agree they shall form part of this application.**

John K Woodmen 04/01/2011  
Signature of Proposed Insured, if age 16 or older Date  
OR Signature of Proposed Adult Applicant

**WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY  
HOME OFFICE - OMAHA, NEBRASKA**

**INSURED** [JOHN X WOODMEN]

**OWNER(S)/CONTROLLER** as named in the application

**EFFECTIVE DATE** [JULY 1, 2011]

**CERTIFICATE** [123456789]

**RATIFICATION OF CHANGE IN COVERAGE APPLIED FOR AND/OR APPLICATION DATED** [date application signed]

1 I hereby agree to the following changes in certificate [123456789]

2 [The waiver rider has not been included on this certificate.]

3 **[IMPORTANT]** - If this form is signed and the required premium has been paid, this certificate will be in force as of the date shown on the certificate, or as of the date this form is signed, whichever comes first. In any event, this form must be signed not later than [August 1, 2010] and returned to the Home Office or the certificate will be canceled.]

If this form is signed, it will be on file. You may request a copy from the Home Office.

- signature(s) required on reverse side -

4

I understand and agree that the foregoing changes are made part of the application and of the certificate issued thereunder. These changes shall be binding on any person who shall have or claim any interest under such certificate.

**SIGNATURE OF OWNER(S)/CONTROLLER**

[JOHN X WOODMEN]

- \_\_\_\_\_

[

- \_\_\_\_\_ ]

[

- \_\_\_\_\_ ]

[

- \_\_\_\_\_ ]

[

- \_\_\_\_\_ ]

**SIGNATURE OF FIELD REPRESENTATIVE**

- \_\_\_\_\_

**DATE**

- \_\_\_\_\_

SERFF Tracking Number:	WDMM-127176233	State:	Arkansas
Filing Company:	Woodmen of the World Life Insurance Society	State Tracking Number:	49432
Company Tracking Number:			
TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
Product Name:	Life App 5055 R-05/11 & Related Forms		
Project Name/Number:	/		

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachments:</b> Rule & Reg 19 Ctn-Apps.pdf Readability Ctn.pdf		
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> Not applicable. <b>Comments:</b>		
<b>Satisfied - Item:</b> Statement of Variability for Form 8217 5-11 <b>Comments:</b> <b>Attachment:</b> 8217 5-11 Rat Variability.pdf		

WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY  
1700 Farnam Street, Omaha, Nebraska 68102

CERTIFICATION

I certify that to the best of my knowledge and belief the form(s) in this submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.

July 22, 2011

\_\_\_\_\_  
Date



\_\_\_\_\_  
Vice President & Chief Actuary

Form(s):

Form 5055 R-05/11

Form 601 R-05/11

Form 943 R-05/11

Form 956 R-05/11

Form 836 R-05/11

Form 8217 5-11

**WOODMEN OF THE WORLD LIFE INSURANCE SOCIETY**  
**1700 Farnam Street, Omaha, Nebraska 68102-2007**

**FLESCH CERTIFICATION**

<b><u>Form Number(s)</u></b>	<b><u>Description</u></b>	<b><u>Flesch Score</u></b>
Form 5055 R-05/11	Application for Individual Life Insurance and Membership	50.2
Form 601 R-05/11	Medical Supplementary Statement	51.3
Form 943 R-05/11	Administrative Supplementary Statement	54.5
Form 956 R-05/11	Underwriting Supplementary Statement	55.6
Form 836 R-05/11	Avocation Questionnaire	62.5
Form 8217 5-11	Ratification Form	61.3

I certify that these Flesch Index numbers are accurate in accordance with the published rules of application of the test.



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Randall P. Rotschafer  
Vice President and Chief Actuary

## **Statement of Variability**

**The following is the statement of variability for Form 8217 5-11 which will be attached to the certificate if one or more of the following situations apply.**

### **Section 1: One of the following statements will print:**

“I hereby agree to the following changes in certificate [123456789]”

“I hereby agree to the following increase in Benefit Amount.”

“I hereby agree to the following increase in Face Amount.”

### **Section 2: One of the following statements will print:**

The waiver rider has been issued at a special class rate on this certificate or increase. This special rating class will increase premiums on traditional life plans or the cost of insurance on universal life plans.

The waiver rider has not been included on this certificate or increase.

The waiver rider has been changed or added to this certificate or increase. Please see the certificate rider for details.

The Accidental Death Benefit Rider has been issued at a special class rate on this certificate or increase. This special rating class will increase premiums on traditional life plans or the cost of insurance on universal life plans.

The Accidental Death Benefit Rider has not been included on this certificate or increase.

The Accidental Death Benefit Rider has been changed or added to this certificate or increase. Please see the certificate rider for details.

The Additional Insurance Option Rider has not been included in this certificate or increase.

The Additional Insurance Option Rider has been changed or added to the certificate or increase. Please see the certificate rider for details.

The Guaranteed Insurability Rider has not been included in this certificate or increase.

The Guaranteed Insurability Rider amount has been changed or the rider has been added to the certificate or increase. Please see the certificate rider for details.

The Applicant Waiver Rider has not been included in this certificate or increase.

The Applicant Waiver Rider has been changed or added to this certificate or increase. Please see the certificate rider for details.

The Accelerated Death Benefit Rider has not been included in this certificate or increase.

This certificate or increase has been issued at a special class rate. This special rating class will increase premiums on traditional life plans or the cost of insurance on universal life plans.

The face amount of insurance for this certificate or increase has been changed. The face amount on the copy of the application has been compared with the new face amount on the certificate or the amendment.

The kind of insurance for this certificate has been changed. The kind of insurance on the copy of the application has been compared with the new kind of insurance on the certificate.

The face amount of insurance for the term rider has been changed. The face amount on the copy of the application has been compared with the new face amount on the term rider.

The kind of insurance for the term rider has been changed. The kind of insurance on the copy of the application has been compared with the new kind of insurance on the term rider.

The term rider has not been included in this certificate.

The cash surrender value will be included in the face amount of insurance.

The cash surrender value will be excluded from the face amount of insurance.

The age for this certificate or increase has been changed.

The Automatic Premium Loan provision has been included in this certificate.

The Automatic Premium Loan provision has not been included in this certificate.

The face amount of insurance for this increase has been issued at a special class rate because of a change in the tobacco rating class. This change will increase the cost of insurance for the increase in face amount.

I understand this certificate has been issued with a tobacco rating class based on the underwriting findings. This classification will increase premiums on traditional life plans or the cost of insurance on universal life plans. It may also affect any refunds.

I understand this certificate has been issued with a tobacco rating class based on the underwriting findings. This classification will increase premiums on traditional life plans or the cost of insurance on universal life plans. It may also affect any refunds and cash values.

I understand that Certificate \_\_\_\_\_ has been exchanged for this certificate; and Certificate \_\_\_\_\_ was issued at a preferred rating class. I further understand that a preferred rating class is not available for this certificate and that this certificate has been issued at a standard rating class which is the best mortality rating available for this product.

The face amount of insurance for this certificate has been changed to prevent the initial premium from exceeding the maximum cash value allowed for life insurance. Please refer to the certificate for the actual face amount.

The application did not specify a planned premium or the planned premium has been increased. To meet minimum premium requirements, this certificate has been issued with a planned premium of \$\_\_\_\_\_.

The planned premium has been changed on this certificate or increase.

The application did not specify an available certificate anniversary age to which planned premiums are payable. This certificate has been issued with planned premiums payable to the certificate anniversary following age 80.

The application did not specify an available certificate anniversary age to which planned premiums are payable. This certificate has been issued with planned premiums payable to the certificate anniversary following age 100.

The application did not specify an available certificate anniversary age to which planned premiums are payable. This certificate has been issued with planned premiums payable to the certificate anniversary following age 120.

If the premium paid at issue or at any time thereafter would cause the certificate to be classified as a modified endowment contract (MEC) because the premium exceeds the amount allowed by the Internal Revenue Code (IRC), I choose to allow the certificate to become a MEC (excess premium is added to the certificate). I understand that distributions from MECs do not have the benefit of the favorable tax rules that typically apply to lifetime distributions from other life insurance contracts and that distributions are subject to a penalty tax unless certain



exceptions apply, such as attaining age 59-1/2. Woodmen has advised me to contact my professional tax advisor for advice about the tax consequences of owning a MEC.

If the premium paid at issue or at any time thereafter would cause the certificate to be classified as a modified endowment contract (MEC) because the premium exceeds the amount allowed by the Internal Revenue Code (IRC), I do not want my certificate to be a MEC. Instead, I choose to place any premiums that would cause an IRC 7-Pay Test failure into the "Advance Premium/Premium Deposit Fund". I approve the transfer of money from the Advance Premium/Premium Deposit Fund to the value of my certificate at the beginning of each certificate year. I understand that the amount transferred will not exceed the amount allowed under the IRC 7-Pay Test based on Woodmen's interpretation of the requirements of the 7-Pay Test.

**Section 3: One of the following statements will print:**

**"IMPORTANT** - If this form is signed and the required premium has been paid, this certificate will be in force as of the date shown on the certificate, or as of the date this form was signed, whichever comes first. In any event, this form must be signed not later than [August 1, 2010] and returned to the Home Office or the certificate will be canceled."

**"IMPORTANT** - If this form is signed and the required premium has been paid, this increase will be in force as of the date shown on the certificate amendment, or as of the date this form was signed, whichever comes first. In any event, this form must be signed not later than [August 1, 2010] and returned to the Home Office or the increase will be canceled."

**"IMPORTANT** - If this form is signed and the required premium has been paid this certificate will be in force as of the date shown on the certificate, or as of the date this form was signed, whichever comes first. This certificate was issued upon exchange or conversion for one or more certificates issued by Woodmen, and coverage under the exchanged or converted certificate(s) continues until this ratification form is signed, but will automatically cease when coverage under this certificate starts. In any event, this form must be signed not later than [August 1, 2010] and returned to the Home Office or the certificate will be cancelled, and the certificate(s) exchanged or converted will continue according to the terms of the certificates as though no exchange or conversion had occurred."

**"IMPORTANT** - If this form is signed and the required premium has been paid this increase will be in force as of the date shown on the certificate amendment, or as of the date this form is signed, whichever comes first. This increase was issued upon exchange or conversion for one or more certificates issued by Woodmen, and coverage under the exchanged or converted certificate(s) continues until this ratification form is signed, but will automatically cease when coverage under this increase starts. In any event, this form must be signed not later than [August 1, 2010] and returned to the Home Office or the increase will be cancelled, and the certificate(s) exchanged or converted will continue according to the terms of the certificates as though no exchange or conversion had occurred."

**Section 4: One of the following statements will print:**

"I understand and agree that the foregoing changes are made part of the application and of the certificate issued thereunder. These changes shall be binding on any person who shall have or claim any interest under such certificate."

"I understand and agree that the foregoing changes are made part of the application and of the increase issued thereunder. These changes shall be binding on any person who shall have or claim any interest under such certificate."